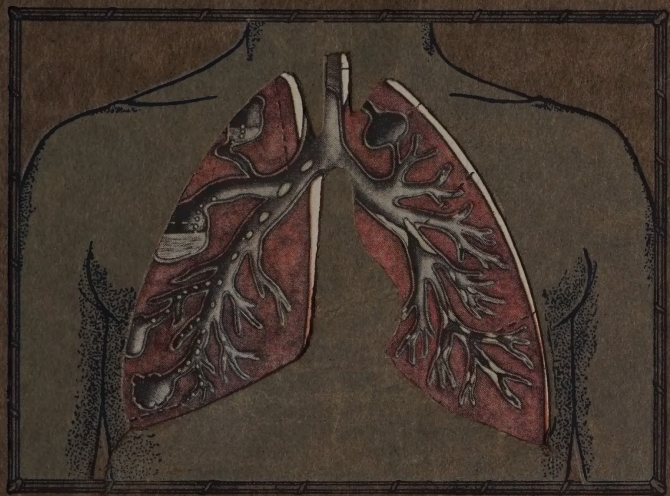
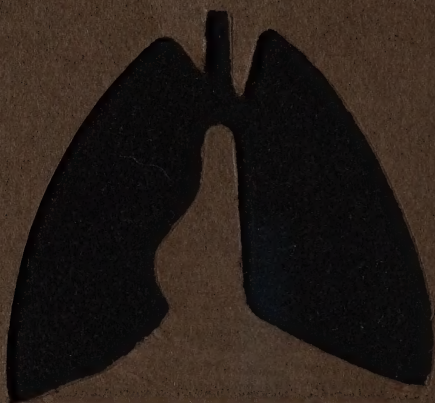


THE PNEUMONIC LUNG



Its Physical Signs
and
Pathology
...

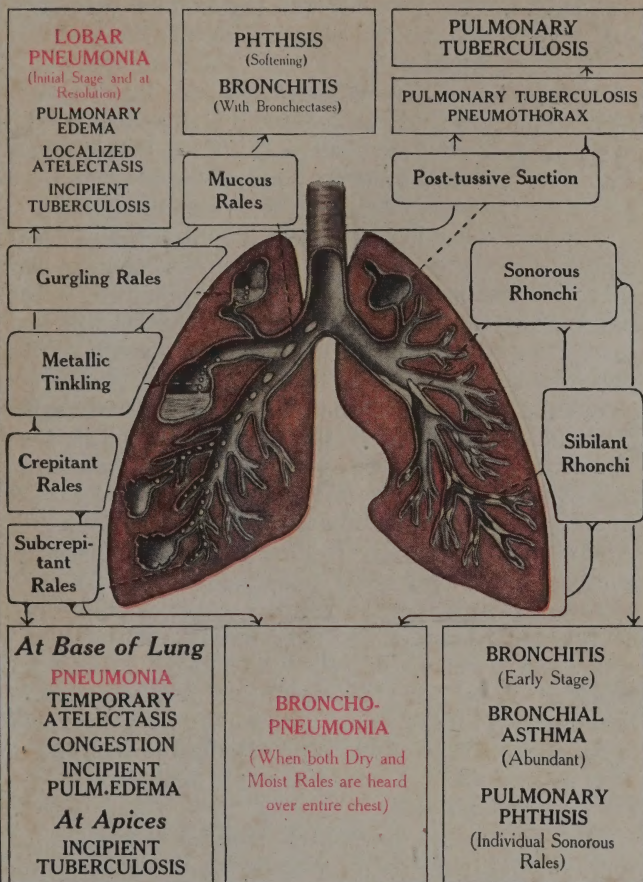


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SCHEMATIC KEY

Physical conditions responsible for accessory sounds heard in Pneumonic and other Pulmonary Diseases



Crepitant Rate -- Separation of walls of alveoli or bronchioles.

Subcrepitant Rate -- Fluid in small bronchi.

Sonorous Rhonchi -- Vibrating mucous or swelling of walls in larger bronchi.

Sibilant Rhonchi -- Vibrating mucous or swelling of walls in bronchioles.

Mucous Rate -- Fluid in larger bronchi.

Gurgling Rate -- Air-bubbles passing through the fluid in a cavity.

Metallic Tinkling -- Liquid dropping upon cavity wall or on fluid.

Post-tussive Suction -- The expansion of a thin-walled cavity after collapse.

INTRODUCTION

“UT with him who serves me with mere words. But he who regaleth me with facts giveth me real pleasure,” is a saying credited to Smollet.

In an age when the written word runs into the millions every year, fearless, indeed, is the writer who dares to produce “mere words”. To hold a reading audience, facts and facts only are an essential and the portrayal of facts is the popular author of the day.

The physician, in his ever constant search for additional knowledge, is entitled to the best there is, and with this end in view, this booklet is presented in the belief that herein the discriminating physician will find some facts which will aid him in the pursuit of his professional duties.

We may be forgiven for a display of pardonable pride in connection with the publication of this particular piece of literature, for it is the most comprehensive of any that this house has given to the profession in an existence of more than a quarter of a century.

The text matter is the result of long and exhaustive study of the literature of pneumonia in its different phases, and in its preparation the works of practically every standard author who has discussed internal medicine have been consulted. The clinical records of hospitals have been a source of information and confirmation, the most recent discussions on pneumonia in American, British and French medical journals have been perused and no field which would yield information has been left untilled.

The illustrations have been painted especially for the illumination of the accompanying text. The subject has been given the closest attention and study and no opportunity has been neglected to attain the close pathological and anatomical touch so essential in bringing out the necessary details, thus adding to their practical value.

Attention is called particularly to the diagrammatic representations of the X-ray appearances, the roentgenoscope offering a valuable aid in determining the nature of certain obscure cases.

Expense has not been a factor in the production of this brochure. With the object of presenting to physicians a booklet which would refresh their knowledge of the etiology, pathology, symptomatology and treatment of a most destructive disease, and in order that they might constantly have at their elbows an authoritative and most practical exposition of the subject, we have gone deeply into the matter. Our experience has been that the profession treasures literature which is instructive and that this literature has a permanent place in the libraries of physicians.

We trust that this brochure may be of real value to its readers in helping to make the path of the pneumonia sufferer less thorny. We confidently believe that Antiphlogistine, when used intelligently and in accordance with rational therapy, is of unequalled value as an adjuvant, which brings relief and comfort to the unfortunate patient who is struggling for breath, as a result of the engorgement of his pulmonary vessels.

The blessed boon of heat in the treatment of pneumonia is too well known to the physician to require elaboration. We know what venesection means when the patient is able to undergo the bleeding. How much easier and better is it to give the sufferer the heat he craves, and at the same time bleed him into his own capillaries through the simple expedient of an Antiphlogistine jacket! Thousands of living monuments to this form of therapy are walking our streets today.

In the hope, therefore, that these pages will influence practitioners to give all their pneumonia patients the same opportunity for life, we take particular pleasure in presenting this booklet to the members of the medical profession.

THE DENVER CHEMICAL MFG. CO.

SYMPTOMS:

Chill:—At onset, often severe, followed by fever.

Temperature:—Rises rapidly from normal to fastigium, 103° or 105° F, usually within first 24 hours, continuous type, slightly remittent. In children and old people rise is less abrupt.

Cough:—Short and dry in early stages, and painful on account of pleural condition. Unproductive.

Respiration:—Becomes rapid—30 to 70 per m. Dyspnea present.

Expectoration:—Mucoid and meagre at first, then mucopurulent and blood-streaked.

PHYSICAL SIGNS:

Inspection:—Patient usually lies on affected side at the beginning of the attack.

Palpation:—Fremitus may be normal or slightly increased if congestion of early stage is present. Physical signs are vague at this stage owing to disturbance of elastic tension and relaxed tissues. Occasionally friction of the pleura may be discovered.

Percussion:—Hyperresonant note is the sign of initial engorgement. Relaxed lung vibrates as a unit, owing to disturbed tone and lessened tension of tissue.

Auscultation:—Weak or even suppressed breath sounds may be noted. During the stage of engorgement, in first 24 hours, the fine crepitant rale (crepitatio indurata) is heard on inspiration.

X-ray:—For several hours after the chill of onset the affected lung shows a clear field; later, an even shadow appears and gradually deepens. When process is not extensive, the middle portion of lung is shown to be the region most often affected. Lung markings enlarged in diseased area.

Pathology:—Affected part congested, dark red and somewhat firm. Capillaries are gorged with blood. Portions cut off will float in water.

Antiphlogistine lessens dyspnea.

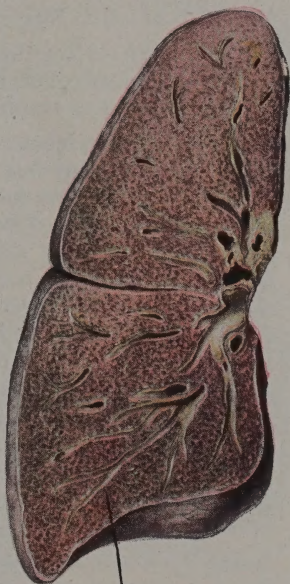
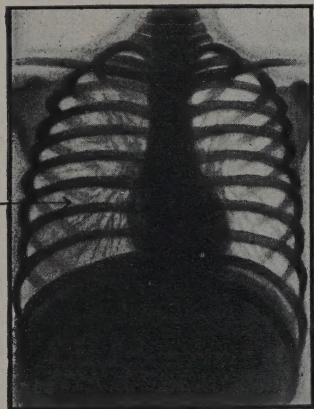
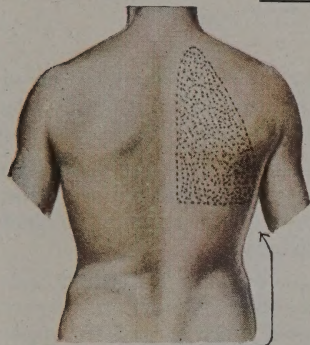
SYMPTOMS (Continued)

Pulse:—At first, small, later strong and bounding.

Pain:—Usually in first 12 hours, often with the chill. There is headache, general aching, and a sensation of oppression; soon a severe pain in the side, distinctly pleuritic in type.

Blood:—A leucocytosis is usually present in all except certain mild and very severe cases. A leucocytosis of 25,000 has been found a few hours after initial chill; 30,000 to 50,000 are possible. Over 90% of cases show pneumococci in the blood.

Treatment:—See page 20.



TISSUE CONGESTED
AND SOMEWHAT FIRM

Antiphlogistine relaxes the muscular and nervous systems.

SYMPTOMS:

Chill:—At onset (see Initial Stage).

Temperature:—Fever continues high with remissions throughout period of hepatization, usually lasting from 3 to 14 days.

Cough:—Becomes frequent, often with severe pain.

Respiration:—Owing to pleural pain breathing is shallow, accelerated in nearly all cases, becoming 30 to 60 per minute in adults, 80 or even higher in children.

Expectoration:—Rusty, blood-streaked, thick and very tenacious.

Pulse:—Full, bounding and rapid, from 100 to 120. In the

PHYSICAL SIGNS:

Inspection:—After the disease is established, the chest movement of affected side is diminished and activity of the muscles of respiration is exaggerated.

Palpation:—Fremitus increased (test should be made after patient has removed obstructive secretion by coughing) unless large bronchi are much blocked by thick secretion or exudate.

Percussion:—With red hepatization, a marked dullness usually appears over consolidated portion. Lower right base is most often affected, may spread to upper lung. Resonance may be found anteriorly after dullness is established by posterior percussion.

Auscultation:—Breath sounds become broncho-vesicular, and then typically bronchial as consolidation develops; bronchophony is heard over the affected area. The fine crepitant rale of the early stage (crepitatio indurata) disappears. Rales may be absent or their presence referable to a bronchitis.

X-ray:—When disease is well defined, a large, quite dense shadow is seen over the consolidation.

Pathology:—Consolidated area is dense, hard and heavy, liver-like and air-less. The cut surface is of a deep-red or mahogany color and dry and rough, due to the slight projection of moulds of fibrin from the air-cells. Portions cut off sink in water.

Antiphlogistine relieves right heart from high blood pressure.

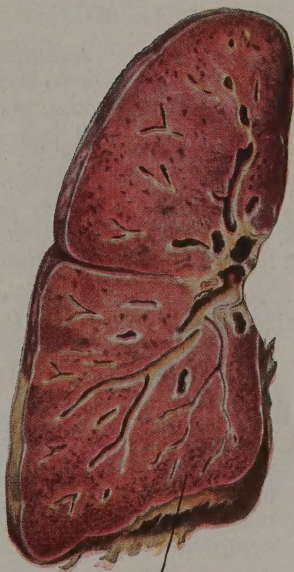
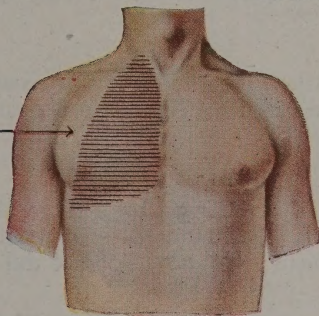
SYMPTOMS (Continued)

aged, the pulse is small and frequent.

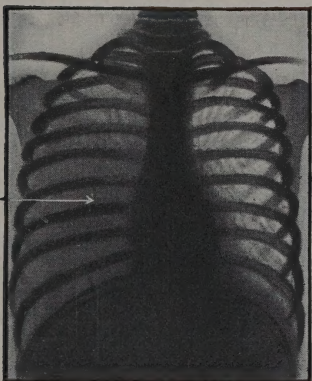
Pain:—Usually present and of pleuritic character.

Blood:—Leucocytosis of from 12,000 to 50,000 or more, the average being 25,000. Blood platelets increased, also amount of fibrin. Maximum leucocytosis commonly occurs before the crisis. Degree of leucocytosis is believed to be in proportion to reaction of the patient to disease. Its absence, with well-defined physical signs, is of very serious import.

Treatment:—See page 20.



LUNG TISSUE FIRM
AND AIRLESS



Antiphlogistine relieves pleuritic pain.

SYMPTOMS:

Chill:—At onset (see Initial Stage).

Temperature:—Fever commonly ends by crisis, and is accompanied by sweating; it may end by lysis. There may be a marked rise in temperature just before crisis, and after crisis temperature usually falls below normal, to 96° or 97° F. Symptoms of collapse may accompany crisis.

Cough:—Becomes less severe about time of crisis.

Respiration:—Becomes slower, drops in accordance with fever but does not decline as rapidly as the temperature and pulse.

Expectoration:—On resolution, sputum becomes creamy in

PHYSICAL SIGNS:

Inspection:—Changes in the thorax and in respiration are seen as patient becomes easier; the whole aspect undergoes a striking change.

Palpation:—Diminished fremitus.

Percussion:—Diminishing dulness appears in stage of resolution, but the percussion sound is somewhat tympanitic for some time after resolution. The dulness diminishes gradually.

Auscultation:—The pure, tubular and bronchial breathing gradually disappears and gives place to the fine crepitant rale (rale redux) of resolution. Later, bubbling rales and moist rales of all sizes may be heard on expiration.

X-ray:—The shadow becomes lighter during this stage; soon after the crisis, the area involved shows a mottled appearance. The shadows gradually fade, but may last for as long as two months after the prominent symptoms have passed.

Pathology:—This is the stage of gray hepatization. The cut surface of the lung is gray, grayish yellow, or whitish gray; some redness may persist. The lung softens, is more crepitant, liquefaction of corpuscles and fibrin takes place, and eventually absorption plus expectoration, removes the products of inflammation.

Antiphlogistine favors resolution.

SYMPTOMS (Continued)

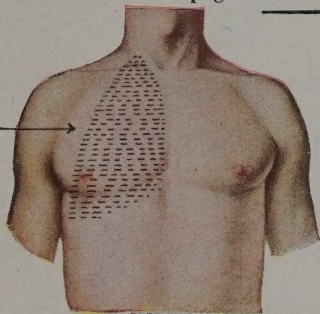
appearance, purulent and often more profuse. "Prune juice" is a very serious sign.

Pulse:—Remains frequent for short period after crisis, gradually subsiding to normal, or sometimes below.

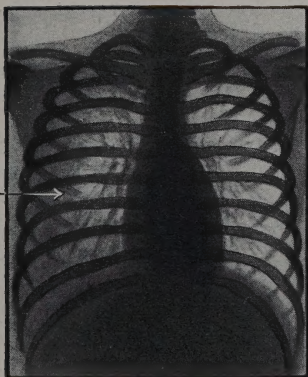
Pain:—Usually disappears soon after crisis.

Blood:—The leucocyte count decreases rapidly after crisis, and usually reaches normal within 2 or 3 days. In attacks that end by lysis, the leucocytosis often decreases more gradually, paralleling, to a certain extent, the temperature change.

Treatment:—See page 20.



LAYER OF FIBRIN
OVER PLEURA



Antiphlogistine accelerates the blood and lymph circulations.

SYMPTOMS:

Chill:—At onset. Symptoms are largely those of a lobar pneumonia and only differ in so far as they are influenced by the fact that the inflammation is confined to the deeper portion of the lung.

Temperature:—Fever present.

Cough:—Usually present.

Respiration:—Quickened.

Expectoration:—Other physical signs may be absent, but rusty sputum, very viscid and tenacious, is diagnostic; it may appear for 4 or 5 days before the physical signs can be discovered.

PHYSICAL SIGNS:

Inspection:—May be nearly negative in early stages of the disease.

Palpation:—Almost negative. Fremitus may be increased in some cases.

Percussion:—May be entirely negative for some days. Dulness is perceptible when hepatization has developed. Some cases first appear at the surface in the axilla of the affected side.

Auscultation:—May be negative. Sometimes, however, faint, tubular breathing is perceptible, but is unusual if affected area is deeply situated in body of the lung.

X-ray:—The consolidated portion will cast a shadow even if deeply situated and is diagnostic even if physical signs are negative. Where other symptoms than fever are inconsiderable and no physical signs are discoverable, the X-ray is very valuable. The shadow often begins near the hilus of the lung and radiates toward the periphery.

Pathology:—Nothing distinctive in the pathology, except the situation of the inflammation distinguishes these cases from typical lobar pneumonia. Resolution may take place even though the physical signs have failed to give anything but the merest evidence of a pneumonic process.

Antiphlogistine tends to limit and prevent consolidation.

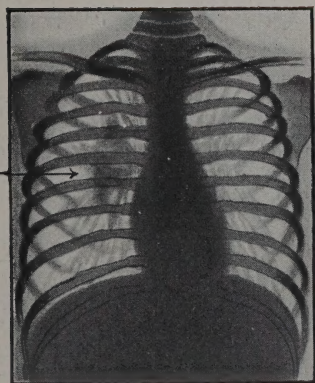
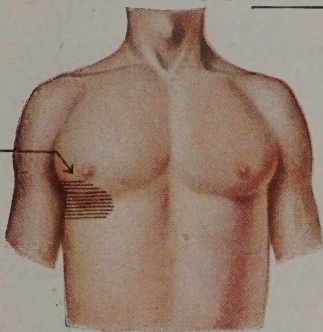
SYMPTOMS (Continued)

Pulse:—Quickened.

Pain:—Absent, or is delayed, and does not occur until the pleura is affected.

Blood:—In the absence of physical signs, the finding of a marked leucocytosis is of diagnostic value. Cabot says that malaria, typhoid and uncomplicated grip are thus ruled out as causative factors in fever, and if scarlet fever and suppuration can be removed from the field of likelihood by other means, pneumonia is strongly suggested.

Treatment:—See page 20.



CONSOLIDATION

Antiphlogistine increases the activity of the blood.

SYMPTOMS:

Chill:—Onset sudden, chill in adult, or with vomiting; sometimes with convulsions in children. More frequently occurs in infants. It is often mistakenly diagnosed.

Temperature:—High fever, which may steadily increase until the disease terminates; varies between 103° and 107° F.

Cough:—Often absent, may be violent and distressing.

Respiration:—Not greatly labored, rapid.

Expectoration:—None in young children.

PHYSICAL SIGNS:

Inspection:—Prostration severe, especially in children.

Palpation:—Fremitus negative or lessened in this type of broncho-pneumonia.

Percussion:—Note may be slightly dulled or normal. —
Usually bilateral.

Auscultation:—May reveal only harsh breath sounds, no rales may be discoverable. One lung may show a greater activity than the other. Sounds not clearly defined.

X-Ray:—Difficult to diagnose. An acute miliary tuberculosis gives a somewhat similar picture to that of an acute broncho-pneumonia in children.

Pathology:—When death occurs in first few days, the lung is usually deeply congested, with the coloring and gross appearance consequent upon this condition.

Upon microscopic examination, the air vesicles are seen to be partly blocked by the results of the pathologic process. Hemorrhagic conditions may be exhibited by pleura. At this stage, however, there is no true hepatization.

When the disease lasts for one or two weeks, it assumes a different character. The lung usually appears with red and gray mottlings and areas of considerable consolidation.

Antiphlogistine assures ease and comfort to the patient.

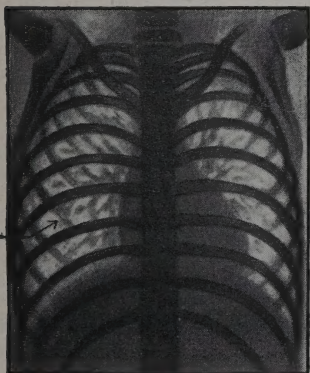
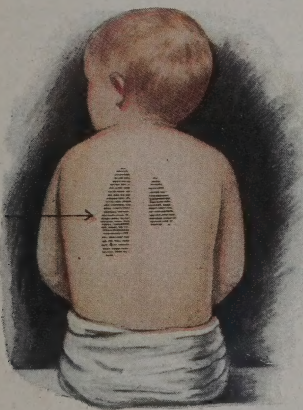
Symptoms (Continued)

Pulse:—Always rapid.

Pain:—Cerebral symptoms often striking. Convulsions not unusual before the end.

Blood:—Sometimes patient's condition is symptomatic of a profound, widely-scattered and general pneumococcus infection.

Treatment:—See page 21.



THE PATH. AND X-RAY PICTURES REPRESENT CASES OF MORE ADVANCED CONSOLIDATION THAN USUALLY ACCOMPANY THE CLINICAL PICTURE DESCRIBED IN THE TEXT.

Antiphlogistine restores the circulation.

SYMPTOMS:

Chill:—May appear without chill or convulsion, as it often follows bronchitis; the onset, however, may be abrupt.

Temperature:—Fever varies from 102° to 104° F. and is decidedly remittent. Infants may have a low temperature. In primary form, an abrupt rise in temperature occurs at onset.

Cough:—Hard and dry, usually persistent and troublesome.

Resp:—40-80, or 120 in some instances. Dyspnea pronounced.

Expectoration:—May be absent in young children. Usually shows the character of common bronchitis, very seldom that of lobar

PHYSICAL SIGNS:

Inspection:—Prostration appears and soon becomes excessive. When extensive consolidation has taken place there may be retraction of ribs on breathing. At first, the physical signs indicate a blocking of the small bronchi.

Palpation:—Vocal fremitus increased if consolidated areas are sufficiently large and near the surface.

Percussion:—Distinct areas of dulness may disappear and again reappear as attack progresses. Except in attacks affecting the apex, and in certain other cases, the dulness of consolidation is usually first observable in the bases and between the scapulae.

Auscultation:—Sibilant and subcrepitant rales are heard in beginning. Later, accompanying the consolidating process, rough or broncho-vesicular respiration becomes manifest. The larger rales may be noticeable, also bronchophony. Auscultation may reveal consolidations where percussion is negative.

X-ray:—Shadows are smaller than those of lobar pneumonia and are scattered in different parts of the lungs. The shading is mottled.

Pathology:—Sectional view presents a mottled appearance, purplish portions being surrounded by areas of dark red color. The hepatization is usually lobular in its distribution, although affected areas may coalesce, simulating lobar pneumonia. Surface is not so rough as in lobar pneumonia.

Antiphlogistine promotes restful, natural sleep.

Symptoms (Continued)

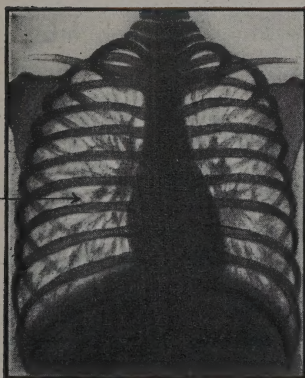
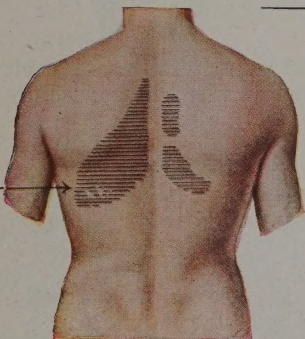
pneumonia: may, however, become rusty and muco-purulent.

Pulse:—Rapid, often irregular, thready; has reached 200.

Pain:—Cough may be painful; both lungs usually involved.

Blood:— Leucocyte count has little diagnostic value in differentiating between broncho-pneumonia and lobar pneumonia, as it is high in both. It may be absent; its presence depending upon the nature of disease to which the broncho-pneumonia is secondary, the general reaction of the patient and other factors.

Treatment:—See page 21.



LOBULAR
HEPATIZATION

Antiphlogistine dilates the superficial blood vessels,

SYMPTOMS:

Chill:—Absent, as disease is chronic and sequel to some other pulmonary disease, possibly acute lobar pneumonia, broncho-pneumonia, etc. Special forms due to the inhalation of dust, etc.

Temperature:—Normal in uncomplicated cases.

Cough:—Usually severe, growing progressively worse.

Respiration:—Dyspnea occurs on slightest exertion.

Expectoration:—Moderate or excessive. Haemoptysis common.

PHYSICAL SIGNS:

Inspection:—Ribs on affected side approximate each other. Spine is curved; muscles of respiration sometimes atrophied.

Palpation:—Vocal fremitus increased if bronchi are not blocked and pleura is not greatly thickened. When left lung is affected, exaggerated cardiac pulsation is evident.

Percussion:—Flat and wooden, except over greatly dilated bronchi where the note will be tympanitic.

Auscultation:—At apex, the breath sounds may be cavernous or amphoric; at base, weak or entirely absent. Sometimes large or small, dry or moist rales are heard. Bronchophony is present. Later, signs of cardiac dilatation may occur.

X-ray:—Conditions characterized by increased fibrous tissue are difficult to diagnose by X-ray. The darkened areas are quite regularly spread throughout the lung.

Pathology:—In cirrhosis, the lung is diminished in size, grayish white or much darkened, particularly in coal-miners. A section reveals bands of fibrous tissue throughout the organ. Bronchi are often enlarged.

Antiphlogistine hastens the elimination of toxins through the skin.

Symptoms (Continued)

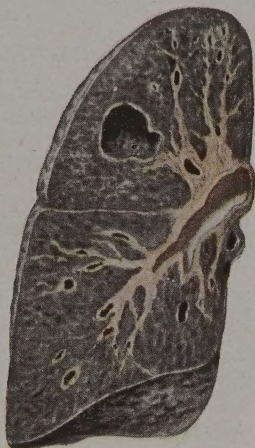
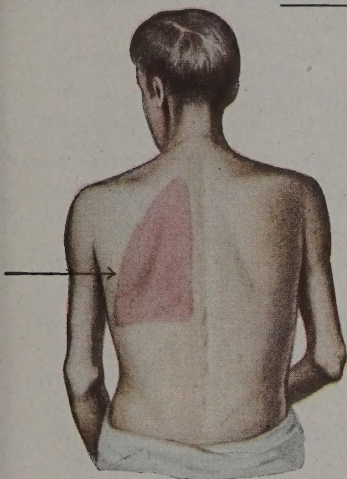
Sputum is muco-purulent; blackish in anthracosis.

Pulse:—If fever is present, pulse will show a character in consonance with particular disease which is responsible for fever.

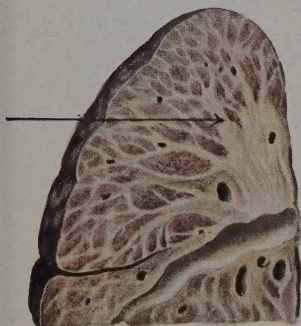
Pain:—May be absent; considerable with pleural adhesions.

Blood:—If pneumonia is associated with tuberculosis, white cells may be more numerous than normal.

Treatment:—See page 22.



ANTHRACOSIS, AND



COAL-DUST
IN THE SPUTUM

Antiphlogistine flushes the superficial capillaries.

SYMPTOMS:—

Chill:—Different cases show decided variations. Repeated chills may occur at onset which is often rapid.

Temperature:—Fever is hectic, high and irregular. Symptoms increase and the typhoid state is sometimes exhibited.

Cough:—Present.

Respiration:—Rapid.

Expectoration:—Usually scanty. It may be slight at first, later profuse with elastic tissue and tubercle bacilli. Haemoptysis occurs. (Sputum may be green.)

PHYSICAL SIGNS:

Inspection:—Early in disease a lessened expansion soon becomes evident.

Palpation:—Vocal fremitus decreased when pleurisy is present.

Percussion:—Dulness appears in scattered areas, notably at apices of lungs.

Auscultation:—As the disease may affect one but usually occurs in both lungs, vesiculo-bronchial breathing will be noted where the process is advancing. Moist and crepitant rales appear. With cavity formation, as the lung undergoes caseation, characteristic sounds will be noted.

X-ray:—Minute tubercular deposits can be demonstrated—a valuable diagnostic factor. The shadows are more mottled than in lobar pneumonia, as a rule, and show less uniform shading.

Pathology:—An exudate is formed that undergoes caseation and the lung tends to cheesy degeneration. The infiltration, at first, is grayish white but becomes yellowish. A rapid excavation with cavity formation often takes place, although occasionally fibrous tissue attempts to form. The destructive process may be very rapid and extensive, even to the extent of destroying the entire lung.

Antiphlogistine relieves tension.

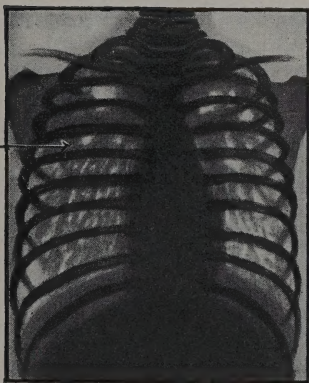
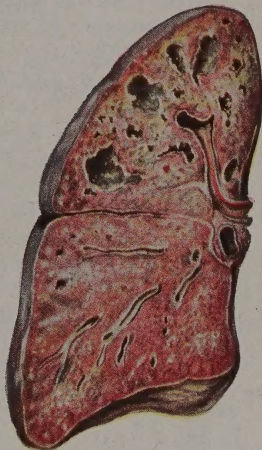
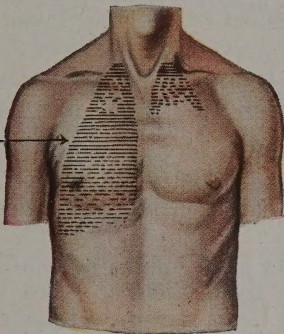
Symptoms (Continued)

Pulse:—Rapid, greatly increased.

Pain:—May be absent; often a sharp pain in side at onset.

Blood:—Pneumonias which accompany tuberculosis usually increase leucocyte count; this is not invariable. In simple tuberculosis, count is usually normal. Suppurating cavities usually raise count; a softening lung sometimes increases it still more.

Treatment:—See page 22.



**TUBERCLE BACILLI (RED)
IN SPUTUM**

Antiphlogistine stimulates the reflexes.

TREATMENT OF LOBAR PNEUMONIA

The latest research, especially that by Avery, Chickering, Cole and Duchez (*Studies from Rockefeller Institute*, Vol. XXIX), demonstrates that lobar pneumonia should be considered as a group of diseases instead of a single disease, owing to the different types of the pneumococcus.

Type 1 is the most common cause of infection and antipneumococcic serum is effective only in Type 1 cases.

The type should first be determined in every case of pneumonia. If of the first type, about 100 c.c. should be given intravenously, provided proper tests show the patient is highly sensitive to horse serum. From 90 to 100 c.c. of serum should be given every eight hours, unless contra-indications are observed. Usually 250 c.c. are sufficient.

The tendency of the serum is to inhibit consolidation, prevent blood invasion by pneumococci and to cause the appearance in the blood-stream of immune bodies.

Hygiene, diet, stimulation, if necessary, and symptomatic treatment are essential. An Antiphlogistine jacket relieves pain and aids in the maintenance of a free, local action of the skin.

TREATMENT OF CENTRAL PNEUMONIA

Especial care is necessary in the treatment of this form of pneumonia, owing to the latent characteristics of the disease.

It is a misleading condition, and as several days may elapse before accurate determination can be made, the physician must continually be on his guard. The type should be carefully studied, and if of the first group, it can be handled accordingly.

One of the first thoughts in this disease is Antiphlogistine, the action of which tends to increase leucocytosis and aid in the development of the anti-bodies so neces-

sary in combating the toxins. Employment of this product obviates the necessity of venesection, and through its physical and therapeutic properties acts as a cotton jacket, counter irritant and analgesic combined.

Conservation of cardiac power is essential, hence the use of depressing drugs should be interdicted. Hydrotherapy is of use in combating high temperature, nervous symptoms, cardiac weakness and dyspnea. The use of ice is not to be commended.

TREATMENT OF ACUTE BRONCHO-PNEUMONIA—CONGESTIVE TYPE

The rapidity with which this disease advances (often resulting fatally in from twenty-four to forty-eight hours) with bilateral signs and every symptom of profound toxemia, makes prompt treatment an urgent necessity. The serum should be used if it can be procured in time. Cardiac stimulation is necessary when the pulse fails and cyanosis increases. The fever is controlled by hydrotherapeutic measures, although it is at times necessary to use a fever mixture. The most comforting therapeutic measure which can be employed is a warm Antiphlogistine jacket. Its effect is to increase the superficial circulation by the induction of artificial hyperemia and the engorged pulmonary vessels are relieved.

Pressure is taken from the heart and a sense of well-being soon takes the place of the agonizing feeling of constriction from which the patient has suffered.

Such an application, made at the onset of the disease, may result most favorably and this boon should be granted in every case.

TREATMENT OF BRONCHO-PNEUMONIA

The war has brought out some valuable information on the treatment of bronchitis. Captain Haultain, R. A. M. C. reports (*Brit. Med. Journal* No. 3043, 1919) after observing a long series of cases, that in over 90 per cent of the cases a Gram-positive streptodiplococcus

was the predominant organism. A vaccine was prepared from several strains and was used in every case showing the typical streptococcus. The first dose is five millions injected subcutaneously, then ten millions two days later; fifteen millions three days after the second and twenty millions four days after the third. A stock mixture of potassium iodide, tincture of belladonna and aromatic spirits of ammonia may also be used, together with the usual stimulants, and oxygen when circumstances warrant.

Aside from a well-ventilated room in which plenty of moist air is present, a jacket poultice is recommended and no more effective means of conveying heat and maintaining it at an equable temperature is known than by an Antiphlogistine jacket.

TREATMENT OF CHRONIC INTERSTITIAL PNEUMONIA

The treatment of this condition is largely symptomatic. The noticeable features, such as the cough, dyspnea and pain, must be combated in the usual manner, and the accompanying bronchitis is treated, as in uncomplicated cases, with Antiphlogistine, etc. Change of climate is an essential.

TREATMENT OF ACUTE PNEUMONIC TUBERCULOSIS

The physician should immediately, upon diagnosis of the condition, treat the case as described under Common Broncho-Pneumonia, in the hope that he may arrest or modify the rapidly acting symptoms.

Antiphlogistine, like all standards, has numerous imitations. The dollar bill has never been successfully imitated. Neither has Antiphlogistine. The careful physician sees to it that when he prescribes Antiphlogistine his patient gets Antiphlogistine and not a substitute which may prove worthless and even harmful.



Pneumonia. I.—Applying Antiphlogistine to the thoracic walls—front, back, and sides. (Patient, of course, should be in a recumbent position).

Pneumonia. II.—Antiphlogistine and cotton jacket complete (Patient recumbent.)



Pneumonia. III — Remove when it will peel off en masse—i. e., in from twelve to thirty-six hours.

DIRECTIONS FOR APPLYING IN PNEUMONIA—Prepare patient in a warm room. Lay on his side and spread Antiphlogistine thick and as hot as can be comfortably borne over one half of the thoracic walls. Cover immediately with a cotton-lined cheesecloth jacket, previously made and warmed. Roll patient over on dressed side and complete application. Stitch front of jacket. Prepare everything beforehand and work as rapidly as possible. Dressing should be renewed when it can be easily peeled off, generally in about twenty-four hours.



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